



Department of Workforce Services

Review / Recertification

Date Received:

YOUR CERTIFICATION PERIOD IS ENDING! Your eligibility needs to be redetermined. Failure to complete and return this review form will result in a delay, reduction or termination of your _____ assistance. Complete this form and return it to the local Department of Workforce Services by the _____ day of _____ . You may call _____ for help with this form.

Please provide your name and address below.

Name: _____ Return this form to: _____

Address: _____

Mailing
Address: _____

Phone No.: _____

If you need help with this recertification form, tell us. A DWS Representative will help you. You have the right to turn in this recertification form today by providing only your name, address, and sign the back page of the form.

COMPLETE YOUR REVIEW ON TIME

If you receive Financial, Medical, Child Care or Food Stamps assistance your case will close at the end of the review month if you do not complete your review. A face to face interview may be required. Completing your review includes providing verifications requested by your worker. You will be notified what verifications are needed.

GOOD CAUSE FOR A LATE REVIEW

If you have a good reason for not completing your review forms on time, please contact your worker at the Department of Workforce Services. Your worker will let you know if completing your review late is approved. If not approved to be late, your case will be closed.

FOLLOW THESE EASY STEPS

1. Return these forms and all requested verifications to your local office. If you only receive Food Stamps, you do not need to answer the questions marked with an asterisk (*). Your worker may request more verifications from you after reviewing your case. You must always verify your income.
2. A face to face interview may be required. If you have someone who is authorized to represent you, they may complete the interview for you. If you need an interpreter, please tell us and we will make arrangements to help you.
3. We encourage you to take or mail these forms to your local office. If an appointment is needed, your worker will schedule an interview. It is your responsibility to reschedule a missed interview. A return envelope is enclosed if you choose to mail your review.
4. If you receive Food Stamps and everyone in your household receives SSI you may turn in your review forms and be interviewed at the local Social Security office.

VOTER REGISTRATION INFORMATION

- If you are not registered to vote where you live now, would you like to register to vote here today? ☐ Yes ☐ No
If you mark yes, you will receive a Voter Registration form.
- Voter registration does not affect the amount of assistance you may receive.
- If you would like help filling out the voter registration form, we will help you. The decision to seek or accept help is yours. You may fill out the registration form in private.
- If you believe someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register, or your right to choose your own political party or other political preference, you may file a complaint with the Lt. Governor of the State of Utah, 203 State Capitol Building, SLC, UT 84114.

CHECK THE BOX IF YOU WANT TO ADD FOOD STAMPS:

☐ **FOOD STAMPS - GIVES THE EXTRA HELP YOU NEED TO BUY FOOD**

IF YOU ARE APPLYING OR RECERTIFYING FOR FOOD STAMPS, please answer these questions about your household.
A Food Stamp household includes your spouse, parents, children, brothers and sisters and ALL other people who live and share food with you.

1. Does your household have LESS than \$100 in cash, checking and savings accounts combined?..... ☐ Yes ☐ No
2. Is your household's total income for this month (before deductions and taxes are taken out)
LESS than \$150? ☐ Yes ☐ No
(Include money received so far this month, AND money you will receive before the end of this month.)

Estimate your household's total gross income for the month..... \$ _____
3. Is the total of your cash, bank accounts and income for this month
less than your total shelter cost (rent or mortgage plus utilities)? ☐ Yes ☐ No
4. Are you a migrant or seasonal farm worker? ☐ Yes ☐ No
 - a. If so, will you receive income later this month?..... ☐ Yes ☐ No
(Include only income you are sure you will receive before the end of the month.)
 - b. How much? \$_____ When?
5. When did you last receive Food Stamps? _____ Where?
6. Are you a boarder?..... ☐ Yes ☐ No
Boarders are individuals who live with others and make payment for lodging and meals.
7. Have you received or are you receiving tribal commodities? ☐ Yes ☐ No

Under penalty of perjury, I swear that the statements on this application are true and correct.

Your Signature	Date	Social Security Number
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Equal Opportunity Employer/Program. Auxiliary aids and services are available upon request to individuals with disabilities by calling (801)-526-9240. Persons with speech or hearing impairments may call the State Relay at 1-800-346-4128.

In accordance with Federal law and the U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs.

<div>Time and Date of Appointment _____</div> <div>Worker to be Seen _____</div> <div>Phone Number _____</div> <div>Expedited Food Stamps <input type="checkbox"/> Yes <input type="checkbox"/> No</div> <div>Reason _____</div> <div>Screened by _____</div> <div>Date _____</div>	<div>COMMENTS</div>
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When your family applies for benefits, you must tell us about the citizenship and immigration status of everyone in your family. Each person in your family must give us his or her social security number. If they don't have one, they must get one. We can help. If anyone in your household does not want to give us information about his or her citizenship, immigration status or social security number, that person can be designated a non-applicant. This means that person will not be considered an applicant and will not be eligible for benefits.

Last Name, First Name, Middle Initial		How Related	Social Security No. Medicare Number	Birth Date	A g e	S e x	Marital Status	Citizen Y/N	Training/ School	
		Self							Grade Completed?	
1	Race _____								Currently Attending? Where?	Yes No
									Grade Completed?	
2	Race _____								Currently Attending? Where?	Yes No
									Grade Completed?	
3	Race _____								Currently Attending? Where?	Yes No
									Grade Completed?	
4	Race _____								Currently Attending? Where?	Yes No
									Grade Completed?	
5	Race _____								Currently Attending? Where?	Yes No
									Grade Completed?	
6	Race _____								Currently Attending? Where?	Yes No
									Grade Completed?	
7	Race _____								Currently Attending? Where?	Yes No
									Grade Completed?	
8	Race _____								Currently Attending? Where?	Yes No

What is the Primary Language Spoken in the Household? _____

*1. Is anyone in your home pregnant? (Medical proof of pregnancy will be required) ☐ Yes ☐ No

Name	Expected Date of Birth
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2. Are you interested in receiving information about adoption assistance? ☐ Yes ☐ No

3. Do you eat with everyone in your home? (List below anyone who doesn't.) ☐ Yes ☐ No

Name

4. Is anyone in your household living in one of these institutions? ☐ Yes ☐ No
☐ Hospital ☐ Shelter ☐ Drug/Rehab Center ☐ Boarding School
☐ Group Home ☐ Nursing Home ☐ Jail-if yes, on work release?

Name	Name of Institution	Admission Date	Release Date
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5. Is anyone 16 or older unable to work because of physical or mental problems? ☐ Yes ☐ No

Name	Date unable to work	When to work?
Medical Problem (a medical verification may be required)		

6. Do you have an authorized representative? ☐ Yes ☐ No
 If you want to choose an adult to help you with your Food Stamps, Medical Card and Check give us that person's name, address and telephone number below. This person will then be your **Authorized Representative**.

Name	Phone #	Relationship
Address	City	State
		Zip

7. Has anyone sold, traded, or given away anything in the last 3 months? ☐ Yes ☐ No
 If yes, please explain:
8. A. Are you a fleeing felon? . . ☐ Yes ☐ No B. Are you violating your probation or parole? ☐ Yes ☐ No
9. Does anyone (including children) have any of the items listed below? ☐ Yes ☐ No
DOES ANYONE HAVE THEIR NAME ON AN ACCOUNT BELONGING TO SOMEONE ELSE? ☐ Yes ☐ No
- | | | |
|--|--|--|
| <input type="checkbox"/> Sa Vings Account | <input type="checkbox"/> P ersonal C hecking Account | <input type="checkbox"/> T rust Fund (TF/TM/TR) |
| <input type="checkbox"/> C redit Union Acct | <input type="checkbox"/> M oney M arket Certificates | <input type="checkbox"/> C ash |
| <input type="checkbox"/> T ime C ertificates | <input type="checkbox"/> S tocks/ B onds | <input type="checkbox"/> O ther |
| <input type="checkbox"/> I RA/ K EOGH/401K | <input type="checkbox"/> P ersonal Needs Account | |

Name of Financial Institution	Account Number	Joint? Yes/No	Type of Acct	Owner/Joint Owners	Amount	Ver	F I A C

10. Does anyone own or is anyone buying any of the types of vehicles listed below, or does anyone have their name on a vehicle belonging to someone else? ☐ Yes ☐ No
- | | | | |
|---|--|---|---|
| <input type="checkbox"/> C ar | <input type="checkbox"/> S now M obile | <input type="checkbox"/> M otor C ycle | <input type="checkbox"/> O ther V ehicle (dune buggy, |
| <input type="checkbox"/> T ruck/ V an | <input type="checkbox"/> M otor H ome | <input type="checkbox"/> B oa T s/ M otors | <input type="checkbox"/> A TV, etc. |

Type of Vehicle	Make	Year/ Model	Licensed Yes/No	State and License #	Owner/Joint Owners	Use	Current Value	Amount Owed	Ver	V E H I

11. Does anyone own, or is anyone buying, any of the types of property listed below?
INCLUDE PROPERTY CO-OWNED WITH SOMEONE NOT LIVING WITH YOU ☐ Yes ☐ No
- | | | |
|---|--|--|
| <input type="checkbox"/> H ome you live in (Exempt) | <input type="checkbox"/> C amper/ T railer(CP/TR) | <input type="checkbox"/> L i F e Insurance (LF/LI) |
| <input type="checkbox"/> O ther Homes | <input type="checkbox"/> N otes or C ontracts (NC/NO) | <input type="checkbox"/> F uneral P lan/ B urial Contract |
| <input type="checkbox"/> T ime S hare Condos | <input type="checkbox"/> S atellite D ish | <input type="checkbox"/> B urial P lans/ C emetery P lots (BS/BC) |
| <input type="checkbox"/> R ental Property | <input type="checkbox"/> L ivestock/ H orses (LC/LX) | <input type="checkbox"/> L ife E states/ L ife Leases |
| <input type="checkbox"/> L and/ M ineral R ights | <input type="checkbox"/> T ools/ E quipment/ I nventory | |
| <input type="checkbox"/> O il or G as Leases | <input type="checkbox"/> O ther | |

Type of Property	Owner/Joint Owners	Joint? Yes/No	Current Face/Market Value	Current Equity/Cash Value	Ver	O T A S

12. Has anyone in your home applied for or is anyone now receiving educational benefits?..... ☐ Yes ☐ No
- ☐ Scholarships (BI/OF/ON) ☐ V.A. Educational Benefits
- ☐ Other Educational Grants and Loans (OD/OE/OF/ON) ☐ PELL/BEOG
- ☐ SEOG ☐ Other (I.E. family, work study, church, employer, etc.)
- ☐ SSIG (ST) ☐ NDSL

School Name: _____	School Name: _____	U N I E
Amount of Benefits: _____	Amount of Benefits: _____	
Time Periods Covered: _____	Time Periods Covered: _____	
Educational Expenses: _____ (tuition, books, fees)	Educational Expenses: _____ (tuition, books, fees)	
Expected Graduation Date: _____ Circle one: Full-time ½ time Less than ½ time	Expected Graduation Date: _____ Circle one: Full-time ½ time Less than ½ time	

13. Has anyone applied for or is anyone now receiving any of these types of UNEARNED INCOME? ☐ Yes ☐ No
- ☐ Social Security ☐ Unemployment Insurance (UC)
- ☐ Church Assistance (CC/IK) ☐ Railroad Retirement ☐ Civil Service Annuity
- ☐ SSI ☐ Workman's Compensation ☐ Inheritances, Settlements, Etc.
- ☐ Child Support ☐ Veteran's Benefits ☐ Cash Gifts (CC)
- ☐ Alimony ☐ Lump Sum Payments ☐ Pension (CV/RT)
- ☐ Other _____
- Are any deductions being withheld from these benefits? (child support taxes, health insurance, overpayments, etc.)
- Explain: _____ ☐ Yes ☐ No

Name	Type of Unearned Income - Claim Number	Denied ? Yes/No	Amount		Date Applied /Received	Date Benefits Will Begin	U N I N
			\$	per			
			\$	per			
			\$	per			

14. Has anyone in your household changed jobs or stopped working in the last 4 months? ☐ Yes ☐ No
- For Food Stamp recipients, has anyone in your household changed jobs or stopped working in the last 60 days? ☐ Yes ☐ No

Name		Name of Employer & Phone Number		Date left job	V O Q S
Date last check received	Reason for leaving	Date expect to return to work	Is it a temporary layoff?		

Name		Name of Employer & Phone Number		Date left job	V O Q S
Date last check received	Reason for leaving	Date expect to return to work	Is it a temporary layoff?		

15. A. Employment information - YOU WILL BE ASKED TO VERIFY THIS INCOME.

NAME					NAME				
Is this a temporary job?		If yes, how long will it last?		What is your hourly wage?	Is this a temporary job?		If yes, how long will it last?		What is your hourly wage?
How often Paid? (circle one): 2X monthly Every 2 weeks Monthly Weekly Daily Hourly Other					How often Paid? (Circle one): 2X monthly Every 2 weeks Monthly Weekly Daily Hourly Other				
Name of Employer (Employer may be contacted), Address and Phone Number					Name of Employer (Employer may be contacted), Address and Phone Number				
Date Started		Average Hours Worked per Week		Day of Month/Wk Paid	Date Started		Average Hours Worked per Week		Day of Month/Wk Paid
Date Paid Day/Mo/Yr	Hours Worked	Gross	Tips	Actual/ Best Est.	Date Paid Day/Mo/Yr	Hours Worked	Gross	Tips	Actual/ Best Est.

B. Are any deductions being withheld from this income? (child support taxes, health insurance, overpayments, etc.) ☐ Yes ☐ No
 If yes, explain: _____ (You will be required to verify)

16. Is anyone in the household SELF - EMPLOYED? ☐ Yes ☐ No

If yes, list the Annual Income: \$ _____ Annual Expenses: \$ _____
 (You will be required to verify the income and expenses.)

17. Do you pay for dependent care so you can go to work, look for work, or get training? ☐ Yes ☐ No

Name of Dependent	Amount Paid Each Month (Attach Receipts)	Who Pays?	Provider Name \ Relationship

18. Do you expect any CHANGES in your circumstances ? ☐ Yes ☐ No
 If yes, check those that apply and explain _____

☐ Earnings ☐ Dependent care ☐ Income ☐ Number of Hours Worked
☐ Resources ☐ Expenses ☐ Living Arrangements ☐ Other _____

19. Are you legally obligated to pay child support to a non-household member? ☐ Yes ☐ No
 If you are paying, how much? _____ You will be required to verify.

*20. If you receive medical assistance, put a check mark in front of any of these expenses paid by anyone in the household.
☐ Tools ☐ Uniforms, Special Clothing (EE) ☐ Mandatory Union Dues
☐ Retirement (MR) ☐ Other

*21. **THIRD PARTY INSURANCE INFORMATION**

A. Do you have health insurance other than Medicaid? <input type="checkbox"/> Yes <input type="checkbox"/> No Insurance Company _____ Phone # _____ Premium \$ _____ How Often _____
B. Have you or any household member been injured in an accident or assault? <input type="checkbox"/> Yes <input type="checkbox"/> No Name of injured person _____ Date if injury _____
C. Do you have both a major medical need (including pregnancy) and either: 1. Insurance available that you have not enrolled in or 2. Insurance that has ended in the past 60 days? <input type="checkbox"/> Yes <input type="checkbox"/> No
D. Is any other person required to pay medical expenses for anyone in your household? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, person's name _____ Phone # _____

- *22. Have you paid any medical bills in the last 3 months or do you have any unpaid bills, such as: (provide verification)
- | | |
|---|---|
| <input type="checkbox"/> Medical, Dental Expenses | <input type="checkbox"/> Hospital or Nursing Care |
| <input type="checkbox"/> Transportation for Medical | <input type="checkbox"/> Medicare Premium/Insurance |
| <input type="checkbox"/> Dentures, Hearing Aids, Eyeglasses | <input type="checkbox"/> Medication (required by Dr.) |
| <input type="checkbox"/> Other (explain) _____ | |

23. Does any person or organization give you money to pay any expenses for you? ☐ Yes ☐ No

Name of Person/Organization	Amount	Type of Expense
	\$	
	\$	

- *24. If you are receiving/applying for Medicaid, is child support or alimony paid by someone in your home who is a spouse or parent of a disabled person (**if yes, provide receipt**)? ☐ Yes ☐ No

- *25. If you are receiving/applying for Medicaid, are there children of a disabled adult or siblings of a disabled person in your home?
 If yes, do these non-disabled people have income? ☐ Yes ☐ No
(Please declare and verify this income in question #15, #16).

FOOD STAMP EMPLOYMENT RULES

26. _____ is the head of household. Circumstances may change who you have designated as head of household. If the **head of household quits a job without a good reason**, the entire household may be disqualified from the Food Stamp Program for three months. The purpose of the Food Stamp Employment and Training Program is to help people get jobs by providing job assistance. Workshops are provided on how to get a job. Anyone may volunteer.

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27. Please check the boxes in front of each expense you pay. These are expenses for which you are responsible.

Expense	Current Amount	Past Due Amount	How Often Billed?	Who is responsible for payment?	Who pays the bill?	Ver	S H E X
<input type="checkbox"/> Rent							
<input type="checkbox"/> Mortgage							
<input type="checkbox"/> Second Mortgage							
<input type="checkbox"/> Trailer Space Lot Payment							
<input type="checkbox"/> Homeless Shelter Costs							
<input type="checkbox"/> Property Taxes (If NOT incl. in mortgage)							
<input type="checkbox"/> Insurance on Home (If NOT incl. in mortgage)							

28. Is your rent government subsidized? ☐ Yes ☐ No If yes, what is the amount YOU pay? \$
 Agency's name _____ Phone # _____ Amount agency pays _____
29. If you are applying/recertifying for Food Stamp benefits, do you have a heating or cooling expense separate from your rent or mortgage costs? ☐ Yes ☐ No
 A. How is your home heated? (gas, electric, etc.,)
 B. How is your home cooled?
 C. I received HEAT/LIHEAP assistance at my current residence in the last year? ☐ Yes ☐ No

30.

Which children need child care?	Why do you need child care? (Check all items appropriate for your family.)					For worker to complete: Is there an approved activity for child care assistance? <input type="checkbox"/> Yes <input type="checkbox"/> No
	Employment - full time	Employment - part time	Self Employment	Education/ Training	Other: What?	

31. Do you have a credit balance with your child care provider?..... ☐ Yes ☐ No
 If yes, how much? \$ _____

Avoid problems! You can avoid problems by making sure you know your rights and responsibilities and the rules for public assistance. Please read the statements below carefully. If you do not understand something, ask your worker about it. Make sure you understand everything before you sign this form.

- Your Social Security Number, as well as other information you give us, will be subject to verification by Federal, State, and local officials. Using the State Income and Eligibility Verification System, we will make sure your household is eligible for Food Stamps and other Federal assistance programs through electronic matches. Computer matching, program reviews, and audits will be done with Department of Workforce Services, Immigration and Naturalization Service, Social Security, and Internal Revenue Service Records. It also includes inquiries to banking and loan institutions and any other organizations or individuals who may have eligibility information about you and other household members. Computer checks will be done when you apply and after you receive assistance. Your benefits to Food Stamps, financial assistance and Medicaid may be reduced, denied, or terminated because of information from these sources. Knowingly providing false information may result in criminal or civil action and/or administrative claims.
- I understand financial assistance for most families is time-limited to a total of 36 months, beginning January 1, 1997. Additional months may be approved if I have a history of working part-time (80 hours a month) while receiving financial assistance or if I have been certified as medically unable to work. The 36 month time limit does not apply when all parents in a household receive SSI assistance or when assistance is being provided to children living with a relative who is not included in the financial assistance.
- I may be contacted by Quality Control to review the eligibility on my assistance. I agree to cooperate with this review.
- You have the right to a hearing before an impartial Administrative Law Judge if the Department of Workforce Services has taken any action with which you disagree.
- **All the members of my household will obey Food Stamp (if applying for or receiving for Food Stamps) and Financial Assistance (if receiving Financial) Program rules. We will not lie or hide information. We will not give Food Stamps to anyone who has no right to use them. We will not use Food Stamps to buy ineligible items. We will not use anyone else's Food Stamps unless we are their authorized representative. If we break any of these rules, we may not be allowed to have Food Stamps or Financial Assistance. The first time, we may not be allowed to have these benefits for 12 months. The second time, 24 months and the third time, we may be permanently disqualified from the Food Stamp or Financial Program. We may also be fined up to \$250,000 or put in jail up to 20 years. We may also be prosecuted under other laws. A court can also order an individual off the program for an additional 18 months. If I use Food Stamps to buy or sell controlled substances (illegal drugs or certain drugs for which a doctor's prescription is required) I can be disqualified from the Food Stamp Program, 24 months for the 1st offense and permanently for the second offense. If I use Food Stamps to buy or sell firearms, ammunition, or explosives I can be disqualified from the Food Stamp Program permanently. An individual will be permanently disqualified if convicted of trafficking Food Stamp benefits of \$500 or more. An individual will be disqualified for 10 years if the person makes fraudulent statements about identity and residence to get multiple benefits.**
- Failure to report or verify any of the above listed expenses will be seen as a statement by your household that you do not want to receive a deduction for the unreported expense.

- **FAMILY PLANNING SERVICES.** Family planning services are available. For information about Family Planning services, contact your local Health Department or call the Utah Family Planning Program at 1-800-826-9662.
- In consideration of Medical Assistance, I assign to the Utah Department of Health all my rights to medical benefits. I authorize payment of the benefits directly to the Department of Health. If the Utah Department of Health pays for my medical care, I will give them any money I collect from an insurance policy. I will also give them any money I collect from someone liable for my medical expenses. I agree to hold harmless any person or organization making payment to the Department of Health because of this agreement.
- Upon approval of medical assistance, I give any and all of my rights to medical support to the Utah Department of Health. I agree to cooperate with the State of Utah to establish and collect alimony and child support for my family. Any person or organization with information about my health or the health of my family may release that information to the Department of Health and a health care provider. DWS and the Department of Health may release information about my medical eligibility status to health care providers.

I (print name), _____ have read or had read to me the statements above. I understand those statements. Under penalty of perjury, I swear the answers I have given on this review are true and correct. I am the person represented by the signature on this document. I understand any false information on this review will result in prosecution for fraud. If I am applying for Food Stamps, I also certify, under penalty of perjury, all household members are U.S. citizens or aliens in lawful immigration status. I understand I may request a fair hearing if I disagree with the decision made on this review, and I have the right to representation at the hearing. I understand that DWS may contact me, or have someone contact me, about the effectiveness of services I received.

CUSTOMER SIGNATURE: _____ Date: _____	AUTHORIZED FOOD STAMP REPRESENTATIVE: _____
SPOUSE OF THE CUSTOMER OR WITNESS SIGNATURE: _____ Date: _____ (Spouse's signature not required for Food Stamps)	<input type="checkbox"/> Approved <input type="checkbox"/> Closure, Code _____ FF. <input type="checkbox"/> Yes <input type="checkbox"/> No Effective Date _____
If the applicant CANNOT write or sign name above, a Mark (X) will be used instead of a signature. One witness is required to verify and witness the applicant's mark; use Spouse Section above.	SIGNATURE OF WORKER: _____ Date: _____